STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF HEALTH PLAN OVERSIGHT

DIVISION OF PLAN SURVEYS

FINAL REPORT OF THE ROUTINE DENTAL SURVEY

UDC DENTAL CALIFORNIA, INC. (UDC)

Issued to Plan October 18, 2001

Final Report of the Routine Dental Survey

UDC Dental California, Inc. (UDC)

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SECTION I. INTRODUCTION

The Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), Section 1380, requires the Department of Managed Health Care (the "Department") to conduct a survey of each licensed health care service plan at least once every three (3) years. The dental survey is a comprehensive evaluation of the Plan's compliance with the Knox-Keene Act. The subjects covered in the survey are listed in Health and Safety Code Section 1380 and in Title 28 of the California Code of Regulations, Section 1300.80.[1] Generally, the subjects of the survey fall into the following categories:

- Plan Organization
- Quality Assurance
- Accessibility of Services
- Continuity of Care
- Grievance System

This Final Report summarizes the findings of the dental survey of UDC Dental California, Inc. (United Dental Care of California, Inc., or UDC; the "Plan"). The Department reviewed the Plan's pre-survey documents that the Plan submitted in response to the Department's survey notification letter. The on-site review was conducted of the Plan on April 16-20 and May 29 and 30, 2001 and an exit conference on July 17, 2001.

The Preliminary Report of the survey findings was sent to the Plan on July 31, 2001. All deficiencies cited in the Preliminary Report required follow-up action by the Plan. The Plan was required to submit a response to the Preliminary Report within 45 days of receipt of the Preliminary Report and submitted a timely response on September 17, 2001.

The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the Plan's Response and the Department's determination concerning the adequacy of the Plan's response. The Plan is required to file any modification to the Exhibits of the Plan's licensing application as a result of the Plan's corrective action plans as an Amendment with the Department.

Any member of the public wanting to read the Plan's entire response and view the Exhibits attached to it may do so by visiting the Department's office in Sacramento, California after October 28, 2001. The Department will also prepare a Summary Report of the Final Report that shall be available to the public at the same time as the Final Report.

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[1] References throughout this report to "Section ____" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as Amended ("the Act"), codified at Health and Safety Code Section 1340 *et seq*. References to "Rule ____" are to the regulations promulgated pursuant to the Act, found at subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations, beginning at Section 1300.43 and transferred to the Department of Managed Health Care pursuant to Section 1341.14.

One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost. Final Reports are available on the Department's web-site: www.dmhc.ca.gov.

The Plan may file an addendum to its response at anytime after the Final Report is issued to the public. Copies of the addendum also are available from the Department at cost. Persons wanting copies of any addenda filed by the Plan should specifically request the addenda in addition to the Plan's response.

Pursuant to Health and Safety Code Section 1380(i)(2), the Department will conduct a Follow-up Review of the Plan within 18 months of the date of the Final Report to determine whether deficiencies identified by the Department have been corrected. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

Finally, Preliminary and Final Reports are "deficiency" reports; that is, the reports focus on deficiencies found during the dental survey. Only specific activities found by the Department to be in need of improvement are included in the report. Omission from the report of other areas of the Plan's performance does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these activities or may not have obtained sufficient information to form a conclusion about the Plan's performance.

Scope of Survey

At the Plan's administrative offices the Department reviewed: (1) 22 grievances filed at the Plan; (2) the Plan's grievance and appeal procedures; (3) information from the Plan's quality assurance system, including minutes of the committees responsible for Plan quality management activities, provider credentialing files, and specialty referral requests; and (4) Plan information for providers describing Plan policies and benefits. The Department also conducted interviews with the Plan staff responsible for these areas.

The staff interviewed included the following:

- Susan Dickey, President
- Jan Stanley, Vice President Operations, Grievance/Resolution Coordinator and Manager of Provider Relations
- Corrine Hanson, Director Quality Improvement
- Dana January, Quality Improvement Specialist (position now open)
- Michael Pink DDS, Dental Director

The Department also reviewed charts of enrollees who had received general dental care at three of the Plan's participating general dental offices; and charts of enrollees who had received orthodontic services at eight of the Plan's participating orthodontic offices. The Department reviewed a total of 18 patient charts from the three general dental practices and 15 patient charts

from the eight orthodontic provider offices.

SECTION II. OVERVIEW OF ORGANIZATION

The following additional background information describes the Plan:

Date Plan Licensed: December 20, 1989

Type of Plan: Specialized Dental Plan

Provider Network: The Plan's dental provider network is comprised of approximately 500 general dentists, 140 orthodontists, and 420 other dental specialists including pedodontists, endodontists, periodontists, and oral surgeons.

The Plan has contracting general and specialty dental providers throughout northern and southern California. The Plan's service area consists of Alameda County, Contra Costa County, Fresno County, Kern County, Los Angeles County, Marin County, Merced County, Napa County, Orange County, Riverside County, Sacramento County, San Bernardino County, San Diego County, San Francisco County, San Joaquin County, San Mateo County, Santa Barbara County, Santa Clara County, Solano County, Sonoma County, Stanislaus County and Ventura County.

The Plan's general dental providers are generally paid a monthly capitation fee, which is a set and agreed to dollar amount per member each month. The terms of these arrangements vary by office. Plan providers also receive compensation from Plan members who pay a defined copayment for specific dental services depending on type of plan copayment schedule. The Plan's dental specialist providers are generally compensated on a fee-for-service or discounted fee-for-service basis.

The Plan requires prior authorization of requests for referrals to dental specialists. However, the Plan uses a direct referral program for orthodontic specialty care that allows general dentists to refer patients directly to a contracted orthodontist for qualifying services without having to submit a specialist authorization request form for prior approval. The Plan is not at risk for orthodontics as the member pays all fees to the specialist based on a negotiated reduced fee schedule. Emergency referrals may be directly referred by the general dentist, however, are subjected to retrospective review. The fees for referrals that cannot be substantiated as necessary for specialty care are charged to the referring dentist and payment deducted from the referring dentist's monthly compensation. When a service is not listed or if the

Plan guidelines indicate that the service is the responsibility of the general dentist, a dentist can submit a prior approval specialist authorization request form describing extenuating circumstances that the dentist believes justify the referral.

Plan Enrollment:

As of April 16, 2001, the Plan had 26,186 members. All of these members were commercial members, and the Dental Plan had no Medicare or Medi-Cal enrollment as of that date.

SECTION III. SUMMARY OF DEFICIENCIES

The Department of Managed Health Care survey of UDC Dental California, Inc. (the "Plan") has found the following deficiencies which the Plan is required to correct:

Plan Organization

Deficiency 1: The Plan does not have the administrative capacity to conduct its Quality Improvement Program. This is a repeat deficiency.

Deficiency 2: The Plan failed to assure that orthodontic care would be rendered by only educationally qualified orthodontists.

Quality Assurance

Deficiency 3: The Plan lacks arrangements with an orthodontic consultant capable of participating with the Plan and rendering decisions concerning the Quality Assurance Program for the Plan's Orthodontic offices. This is a repeat deficiency.

Deficiency 4: The Plan's Quality Assurance Program did not ensure the consistent identification and correction of dental quality issues raised by enrollee complaints. This is a repeat deficiency.

- **a. The Plan did not adequately and consistently evaluate grievances.**
- **b. The Plan did not adequately follow up enrollee complaints to determine if they represent systemic deficiencies in quality care at Plan participating dental practices.**

Deficiency 5: The Plan's Quality Assurance Program did not ensure the consistent identification and correction of quality of care issues at the Plan's general dental offices. This is a repeat deficiency.

- **a. The Plan's method of selecting the sample of patient charts for audits of general dental practices was inadequate.**
- **b. The Plan's data collection process and utilization reports do not provide utilization information on individual members.**
- **c. The Plan's audits of its general dental practices did not identify deficiencies in the quality of care.**
- **d. The Plan failed to demonstrate effective action to correct deficiencies that it had identified in its audits of general dental practices.**

Deficiency 6: The Plan did not follow its own standards for Quality Assurance audits.

Deficiency 7: The Plan's Quality Assurance Program did not ensure the consistent identification and correction of quality of care issues at the Plan's orthodontic practices. This is a repeat deficiency.

a. The Plan's orthodontic audit tool was deficient because it did not include a number of important elements.

b. The Plan's method of selecting the sample of patient charts for audits of orthodontic practices was inadequate.

c. The Plan's audits of its orthodontic practices did not consistently identify deficiencies in the quality of care.

d. The Plan failed to adequately follow up quality deficiencies with its orthodontic providers by informing them of Plan audit results and necessary corrective actions.

Deficiency 8: The Plan's Quality Assurance Program failed to demonstrate adequate evidence of credentialing and recredentialing of providers. This is a repeat deficiency.

Grievance System

Deficiency 9: The Plan did not ensure adequate follow up of access-related complaints to determine whether complaints are representative of systemic problems with providers and to initiate appropriate corrective actions, where necessary.

Continuity of Care

Deficiency 10: The Plan has adopted limitations on referrals for children for pedodontic services based on age.

SECTION IV. SUMMARY OF PLAN'S EFFORTS TO CORRECT DEFICIENCIES

Upon reviewing the Plan's response to the Preliminary Report, the Department found that the Plan had fully corrected the following deficiencies:

Continuity of Care**,** Deficiency 10. The Plan has adopted limitations on referrals for children for pedodontic services based on age.

For all other Deficiencies cited, the Department found that although the Plan had initiated corrective actions, full implementation of those actions, and assessment of the effectiveness, will

require more than forty-five (45) days. Therefore, at the time of the Follow-up Review, the Department will review the Plan's activities to assess the efficacy of the Corrective Action Plans (CAPs) in remedying issues of non-compliance.

SECTION V. DISCUSSION OF DEFICIENCIES AND CORRECTIVE ACTIONS

A. Plan Organization

Deficiency 1: The Plan does not have the administrative capacity to conduct its Quality Improvement Program. This is a repeat deficiency.

Section 1370 states, in part, that every plan shall establish procedures in accordance with Department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

Section 1367 (b) states, in part, that all personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

Rule 1300.67.3 (a) (2) states, in part, that staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

The Department's September 24, 1999 Public/Final Report of Survey had a similar finding of a lack of administrative capacity. The Plan was to submit the following corrective action with the Department:

a. Evidence that the Quality Improvement (QI) Specialist's time dedication to the Plan's Quality Assurance (QA) Program is sufficient to conduct all responsibilities outlined in the QA Program Description including an estimated breakdown of time dedication, on at least a monthly basis, to each specific responsibility for this position; and

b. Revision of the Plan's organizational arrangements to assure that the responsibility for conducting the Plan's QA program is retained by the Plan.

The Plan responded to the Department's corrective action in a submission dated October 11, 2000. At the time of this current survey a number of personnel changes have occurred at the Plan as follows:

- The Director of Quality Improvement resides and works in Texas.

- The QI Specialist position is presently vacant. The Quality Improvement Specialist is responsible for coordination of QI activities including provider site visits, QI meetings, provider credentialing and recredentialing, coordination with customer services grievance information in provider files, coordination with Provider Service department regarding

specialty referrals maintained in provider files, providing quarterly reports to the QI committee and senior management on credentialing activities. The QI Specialist provided a large number of other services.

- The Grievance/Resolution Coordinator is no longer employed by the Plan and that position is vacant. From information gained during interviews of Plan staff, the Grievance/Resolution Coordinator position will not be filled.

- The Plan no longer employs provider service representatives in the field. These representatives formerly conducted new provider recruitment, facility audits, access monitoring and follow up on grievance issues that may have involved a systemic issue.

- The Vice President of Operations is presently responsible for grievance resolution, customer service, provider relations, and almost all administrative functions except those directly related to the Dental Director. It is unclear who will conduct those functions that were formerly the responsibility of the QI Specialist and Grievance/Resolution Coordinator.

Corrective Action 1:

The Plan shall submit evidence that it has adequate staff to conduct the required elements of the Quality Improvement (QI) Program. The submission shall specify which staff will immediately respond to issues raised in all member complaints. The Plan shall submit the qualifications of new staff and their job descriptions. The submission shall contain a revised organization chart that identifies job titles and reporting responsibilities. The Plan shall demonstrate that Plan staff is immediately available to direct the activities of the Quality Assurance Program on a daily basis.

Plan's Compliance Effort 1:

At the time of the Department's on-site dental survey, UDC had a full-time position devoted to the QI program. The QI Specialists reported directly to the plan president and her time dedication included the credentialing and recredentialing of network providers and the responsibilities associated with the ongoing QI program. The Protective Dental Care's (UDC's Parent Company) QI Director, a Texas resident, was available to the local QI Specialist in a consulting capacity; however, she was not directly involved in the California program. To avoid further confusion regarding this point, the director's position has been deleted from the functional organizational chart. Following the first on-site visit, Daenna January, the QI Specialist informed UDC management that she would be leaving her position to travel to Europe. Immediately the VP of Operations began training in the job responsibilities to assure that the ongoing QI activities continued without interruption. In addition to assuming the responsibilities for the QI program, the VP of Operations has also assumed responsibility for the resolution of member grievances.

As noted in our cover letter, Fortis, Inc. has purchased UDC, and an integration strategy being discussed involves the possible exit from the state. The decision should be reached on or before

January 1, 2002. If the ultimate decision is made to continue operations in the state, UDC will adjust staffing accordingly. However, at the current time there are less than 20,000 members in the plan and the plan is receiving on the average 2 member complaints a month. It is Plan's determination that the staffing is adequate given the distribution of responsibilities as demonstrated on the attached organizational chart.

The Plan submitted three exhibits in support of its proposed corrective action plan (Exhibits A, B & C): Exhibit A: UDC of California, Inc., Organizational Chart; Exhibit B: UDC Key Personnel - Job Descriptions; and Exhibit C: List of Dental Consultants Performing General Dental & Orthodontic Audits.

Department's Finding Concerning Plan's Compliance Effort 1:

The Department's corrective action measures were not followed, but rather, the Plan reorganized all prior QA functions under the Vice President of Operation's responsibility with no additional staff support. The same deficiency currently exists that was present during the Department's on-site review plus its significance is now exacerbated as the QI Specialist has departed and all credentialing and re-credentialing activities are now the Vice President's responsibility. For example, the VP of Operations is responsible for all Quality Improvement functions such as, but not limited to:

1. Managing day to day office administration;
2. Member services management, i.e., complaint resolution;
3. Provider network management;
4. Credentialing and re-credentialing;
5. Preparation of QA Committee meeting agenda and information packets for members;
6. Preparation of QA Committee Meeting minutes;
7. Development of the QI work plan and monitoring compliance with timeframes for completion of QI activities;
8. Assisting the Dental Director with QI activities and maintaining appropriate documentation; and
9. Preparation of tabulated grievances report for presentation to QI Committee, Board of Directors and Public Policy Committee.

The Plan does not have the administrative capacity to conduct its Quality Improvement Program. The Plan's proposed Corrective Action Plan (CAP) is not adequate to remedy the deficiency as requested. This is a repeat deficiency. The Department will conduct a Follow-Up Review within 18 months of the date of the Final Report to determine whether the deficiency identified by the Department has been corrected.

Deficiency 2: The Plan failed to assure that orthodontic care would be rendered by only educationally qualified orthodontists.

Section 1367 (b) states, in part, that all personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is

required by law.

The orthodontic schedule of benefits lists a variety of fees for the same service under the same Plan number for family dentists, Board eligible general dentists, and specialists. "Board eligible general dentists" is not a standard term and its meaning is unclear. The use of "general dentist" would indicate that such a dentist is not the academic equivalent of Board eligible orthodontists. "Board eligible" refers only to those orthodontists who have successfully completed a course of instruction from an accredited teaching institution with a certificate of completion in orthodontics.

Corrective Action 2:

The Plan shall clarify its schedule of benefits for orthodontic services so that orthodontic services generally regarded as requiring care of a specialist are provided by educationally qualified orthodontists. The Plan shall clarify the Plan's definition of providers under each category.

Plan's Compliance Effort 2:

The schedules of benefits for the plans in questions (plans 185-A and 385-A) are being revised and filed to specify orthodontic treatment by dentists who are board eligible in orthodontists only, and not general dentists. The Plan submitted an exhibit (Exhibit D: Schedule of Benefits) to its response demonstrating the proposed changes.

Department's Finding Concerning Plan's Compliance Effort 2:

The Plan submitted its proposed revisions to the Schedules of Benefits, however the Schedules have not been revised, reprinted and distributed to providers and enrollees.

The Plan's proposed CAP will take longer than 45 days to implement. The Department will conduct a Follow-Up Review within 18 months of the date of the Final Report to determine whether the deficiency identified by the Department has been corrected.

B. Quality Assurance

Deficiency 3: The Plan lacks arrangements with an orthodontic consultant capable of participating with the Plan and rendering decisions concerning the Quality Assurance Program for the Plan's Orthodontic offices. This is a repeat deficiency.

Section 1370 states, in part, that every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

The Plan has an arrangement with independent auditors to conduct audits of its orthodontic providers. The orthodontist/auditors perform audits only and are not consultants to the Plan on

matters such as follow up to audit findings and evaluation and resolution of orthodontic grievances.

Corrective Action 3:

The Plan shall submit evidence of an agreement with an independent orthodontic auditor licensed in California to participate in the Plan's orthodontic quality assurance program including reviewing quality of care grievances submitted by enrollees concerning the quality of orthodontic services. That individual shall be licensed to practice dentistry in California. The Plan's submission shall include a revised organizational chart which shows the position of the orthodontic auditor.

Plan's Compliance Effort 3:

Dr. James F. Loos (license 16210, M.S. in Orthodontics) is the independent orthodontic auditor responsible for QA audits of the Plan's orthodontic offices, directing additional orthodontist to assist in these audits. This arrangement has been in existence since July of 1999. Dr. Loos also participates in the QA Committee meetings, providing consulting on any orthodontic issues that arise from audits or grievances pertaining to orthodontic care. The Plan submitted a description of this agreement (Exhibit E: Addendum to Orthodontic Agreement for James F. Loos, DDS) and an organizational chart (Exhibit A: UDC of California, Inc., Organizational Chart).

Department's Finding Concerning Plan's Compliance Effort 3:

The Plan submitted a copy of a proposed addendum to an orthodontist consultant's contract. However, the addendum was not signed or dated by either the orthodontic consultant or any representative of the Plan. The proposed addendum submitted by the Plan does not provide evidence of an executed agreement between the Plan and an orthodontic consultant.

The Plan's proposed CAP will take longer than 45 days to implement. The Department will conduct a Follow-Up Review within 18 months of the date of the Final Report to determine whether the deficiency identified by the Department has been corrected.

Deficiency 4: The Plan's Quality Assurance Program did not ensure the consistent identification and correction of dental quality issues raised by enrollee complaints. This is a repeat deficiency.

Section 1368(a)(1) states, in part, that the plan shall establish a grievance system which ensures adequate consideration of enrollee grievances.

Rule 1300.70(a)(1) states, in part, that the QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Rule 1300.70 (b) (1) (A) and (B) states, in part, that each plan's quality assurance program to be designed to ensure that: (i) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees; (ii) quality of care problems are identified and corrected for all provider entities.

a. The Plan did not consistently and adequately evaluate grievances.

The Department found that in four of the 22 grievances reviewed (18%), the Plan resolved the grievance in favor of the provider without adequate investigation and follow up with the provider. The Department's review found that three cases were incorrectly resolved in favor of the provider. In a fourth case, the Plan failed to identify a significant problem in the complaint and only addressed part of the patient's grievance. Those four cases are described below:

Case 2: There was no follow up with the provider to determine if the member's allegation of refusal to treat was true. The grievance closed in favor of the provider because member failed to return written Unusual Incident Report (UIR).

Case 3: The member refused to sign an agreement with the provider to pay $50 for a broken appointment. Plan 105 allows the provider to charge $15 for a broken appointment. The provider refused to see patient and Plan transferred patient. The Plan followed up with provider's office, verified the patient's complaint, however, the Plan took no corrective action with the provider.

Case 19: The patient alleged she was denied a prophylaxis because she refused to have several old fillings replaced first. The Plan Dental Director obtained the patient's chart and notified the patient that the provider correctly diagnosed and treatment planned four quadrants of scaling and root planning that must be completed before she could have a prophylaxis. The Dental Director's statement was not what the dental record demonstrated. A review of the dental record by the Department supported the patient's allegation that provider said she must have four existing restorations replaced before she may receive a prophylaxis. This patient had no treatment plan for four quadrants of scaling and root planning as the dental director stated in his resolution letter.

Case 10: In addition to an oral surgery issue that was properly resolved, the patient alleged the office was dirty and unkept. This issue of office cleanliness was not identified or followed up in the Plan's review.

b. The Plan did not adequately follow up enrollee complaints to determine if they represent systemic deficiencies in quality care at Plan participating dental practices.

The Department found that seven of 22 complaints that the Department reviewed (case #1, 2, 3, 4, 10, 13 and 17) raised potential dental quality issues. The Plan failed to provide evidence of adequate follow up, including follow up with providers, to determine whether complaints were representative of systemic quality issues at Plan provider offices and to ensure remediation of identified quality issues. A summary of four of these cases follows:

Case 1: The member complained of a dirty office, unsanitary conditions and unreasonable waiting time in the office. A Plan staff member made a phone call to the office however, no Plan staff visited the office to follow up on the alleged unsanitary conditions or access issues.

Case 4: The Plan telephoned the provider and confirmed the member's complaint which was that the patient could not get an initial examination appointment for over six weeks. The Plan's accessibility standard is within three weeks for initial appointment. The Plan did verify the member's complaint, however there was no corrective action of the systemic issue at that office.

Case 13: The office staff was rude to the member and the human resources manager at the member's employer. The Plan filed the complaint in the provider file, however there was no follow up with the provider regarding his staff's rudeness.

Case 17: The member alleged his examination, x-rays, cleaning, and polish lasted no more than 15 minutes and that the cleaning was less than five minutes. The Plan responded to the member that his concerns would be addressed at the provider's next quality assurance review. However, a Plan auditor stated, during the Department's survey, that the auditor is not informed about any grievances or past provider audits when conducting quality assurance reviews.

During scheduled interviews of Plan staff, it was discovered that the Plan no longer employs provider relations representatives who work in the field recruiting new offices, making service calls on providers, conducting facility and access monitoring visits or following up on complaints involving issues of unsanitary conditions, cleanliness, or access. The reason given for no longer employing field representatives was the Plan has a large stable network of providers and is not in need of further recruitment.

Corrective Action 4:

The Plan shall submit a corrective action plan which includes, but not limited to, the implementation and development of procedures and timeframes to ensure the following:

a. The Plan's dental professional staff adequately and consistently investigate and follow up potential quality issues and systemic issues raised by individual enrollee complaints, including review of all relevant clinical records, to ensure optimal treatment outcomes for patients. The Plan's corrective action plan shall address the roles of all Plan-designated dental professionals involved in these processes, including the Dental Director, the Plan's orthodontic consultant or auditor, and all QA and Peer Review committees responsible for dental professional review and decision-making; and

b. Where complaints raise potential unsanitary or systemic access issues with providers, the appropriate Plan's staff will conduct adequate follow up with contracting provider offices to determine whether unsanitary conditions or access concerns are representative of systemic issues and to initiate and monitor appropriate corrective actions with such providers.

Plan's Compliance Effort 4:

The current policy in place for complaint resolution is to contact the provider office in question on all complaints. The Plan refers to its policy and procedure (Exhibit F: UDC Policy/Procedure, Member and Provider Complaints, revised 10/1/00) regarding Complaint/Grievance Resolution procedures. A quality of care issue that requires review of dental records is forwarded to the Dental Director for review, or, if the QA Committee meeting is within the timeframe for resolving the grievance, the committee reviews the records. For complaints that raise potential unsanitary or systemic access issues, one of the dental auditors will conduct an on-site audit of the office and report back to the Plan, who will initiate any necessary corrective actions with the provider.

Department's Finding Concerning Plan's Compliance Effort 4:

The Plan's response to the Preliminary Report refers to Exhibit F (UDC Policy/Procedure: Member and Provider Complaints) for its corrective action response. These Policies and Procedures were issued on 8/1/99 and last revised on 10/1/00. This Policy and Procedure describes the function of the Resolution Coordinator who is no longer employed and that responsibility has been transferred to the VP of Operations. The Policy and Procedure describes how member transfer requests are forwarded to the Provider Relations Representative however, there is currently no Provider Relations Representative other than the VP of Operations. This Policy and Procedure states that complaints of a clinical nature go to a Dental Advisor or the Dental Director however, there is currently no position of Dental Advisor at UDC.

In reference to this Policy and Procedure, Section III(2)(H)(iv) states, in part, " If the complaint is regarding appointment access or poor dental chairside manner in the dentist's office, the Resolution Coordinator may send the case to the Dental Advisor, the Dental Director, Quality Improvement Specialist and/or the Provider Relations Manager for resolution." Presently, the only persons identified above are the Dental Director and the VP of Operations who has assumed all duties and responsibilities for QA other than the Dental Director.

These Policies and Procedures have not been revised since 10/1/00 and do not represent the current state of operations at the Plan. The original findings in the preliminary report remain. The Plan's CAP is not adequate to remedy the deficiency as requested. The Department will conduct a Follow-Up Review within 18 months of the date of the Final Report to determine whether the deficiency identified by the Department has been corrected.

Deficiency 5: The Plan's Quality Assurance Program did not ensure the consistent identification and correction of quality of care issues at the Plan's general dental offices. This is a repeat deficiency.

Section 1370, Rule 1300.70(a)(1), and Rule 1300.70(b)(1)(A) and (B) stated above.

a. The Plan's method of selecting the sample of patient charts for audits of general dental practices was inadequate.

During the Plan's provider audit, the patient sample was selected by the provider. This allows the dental practice to select only those patient records for which the provider believes an acceptable level of care was provided. The Plan's Quality Improvement Program does not specify any method of chart selection. In two of the three offices reviewed by the Plan and the Department, only five of 10 selected charts were reviewed by the auditor. In offices #1 and #3 there was very little treatment rendered. In office #1, five patients had a total of ten visits which does not allow sufficient treatment for a quality of care review. In office #3, five patients had examinations, x-rays, prophylaxis and in the total patient sample there were one crown and two amalgam restorations. Again, the patient sample for office #3 was inadequate for a quality of care review.

b. The Plan's data collection process and utilization reports do not provide information on individual members.

Since the Plan's last survey by the Department, the Plan has developed a system to use encounter data to provide utilization reports that analyze the utilization of services at provider offices. These reports assist Plan administration in evaluating under and over utilization of services at provider offices. The reports are also helpful in establishing norms within the UDC provider network.

The Dental Director stated, during scheduled interviews, that there is no report available to him that provides information on utilization of services of individual members. Without a report of member utilization, it is not possible for the Plan to select charts that have a broad range of services over an adequate period of time for meaningful quality assurance review. The lack of individual member utilization reports contributes to the deficiency reported above (Deficiency 5a).

c. The Plan's audits of its general dental practices did not identify deficiencies in the quality of care.

The Department reviewed the same records that were used by the Plan in its most recent audit of three practices. The purpose of this was to determine if the Plan's audits were consistently detecting deficiencies. Ten records were to be evaluated by the Plan at each practice. The Plan was unable to provide copies of all ten records in any of the practices. In office #1, only five records were reviewed by the Plan and all five records were provided to the Department. In office #2, ten charts were reviewed by the Plan, only nine of which were available for Department review. In office #3, ten charts were reviewed by the Plan, however the Plan evaluated only parts (about 1/2) of the quality of care criteria on each chart and only five charts were obtained for the Department's evaluation. It was not possible for the Department to make a complete direct comparison of quality of care items for office #3 since the Plan only evaluated part of each record and the Department only received one half of the charts. The number of records provided to the Department for its review is shown in Table 1.

Number of records in Plan audit and number supplied to the Department.

	# charts in Plan sample	# charts supplied to the Department
Office 1	5	5
Office 2	10	9
Office 3	10	5

The following are instances in which the Plan found the quality of care to be acceptable or not applicable whereas the Department found the care below professionally recognized standards of practice.

Practice #1: Deficiencies identified by the Department and not by the Plan

Case 1-2. There was a lack of periodontal diagnosis and documentation.

Case 1-3. The progress notes in the patient record were illegible.

Case 1-4. There was a lack of periodontal diagnosis and documentation. There was a lack of documentation of local anesthetic use for periodontal treatment and six restorations. The Plan did not identify overcharging as an issue. The patient had Plan 180B which has a co-payment of $45 for each one surface resin. The provider charged the patient $750 for the six one surface resin restorations (average of $125) and told the patient that it was not a covered benefit.

Case 1-5. There was a lack of periodontal diagnosis and documentation. The progress notes were illegible.

Practice #2: Deficiencies identified by the Department and not by the Plan

In all ten cases the medical history was taken in a manner which made it impossible to determine if the patient was completely healthy or if the patient failed to complete the medical history.

Practice #3: Deficiencies identified by the Department and not by the Plan

Case 3-1. Treatment was rendered out of sequence with no explanation as to reason.

Case 3-4. Too few x-rays were taken at initial examination. Oral hygiene instructions were not documented.

Case 3-6. Too few x-rays were taken at initial examination. The patient had two anterior periapical and four bitewing x-rays. The patient had nine existing crowns at the time of the initial examination and periapical films of these teeth were indicated.

d. The Plan failed to demonstrate effective action to correct deficiencies that it had identified in its audits of general dental offices.

The Plan's Corrective Action Plans were ineffective in two practices as follows:

Practice #1:

The provider was audited on July 26, 1996 and the Plan identified 21 deficiencies. The Plan notified the provider of the deficiencies and stated it would conduct a re-audit in three months. The Plan failed to conduct the audit as indicated. The next audit was January 19, 2000, three and a half years rather than three months. The Plan did not follow up on the provider's deficiencies as stated in the Plan's Quality Improvement Program.

Practice #3:

The practice had been audited by the Plan on January 19, 1999. The Plan found the following deficiencies: a lack of documentation of oral hygiene instruction in four of five patients; no recall dates or documentation indicated; and a lack of documentation of professional review of the patient's medical history. There was no follow up letter sent to the provider indicating the deficiencies and requesting corrective action. As a result, no corrective action could be expected by the provider.

Corrective Action 5:

The Plan shall submit a Quality Assurance Program which consistently identifies dental quality issues at the Plan's general dental offices and ensuring that quality problems are corrected on a timely basis including, but not limited to, the following:

a. The Plan shall submit a revised Quality Assurance plan to ensure that the Plan's sampling of patient records selected for general dental practice and orthodontic audits produces a sample which permits evaluation of a broad range of care and that the Plan and not the practice select the patient records to be audited.

b. The Plan shall submit a revised utilization reporting format that includes, but is not limited to, reporting utilization of services by individual members. The Plan shall develop a mechanism to provide an appropriate number of enrollee charts so that audits are representative of actual practice. The individual member utilization reports shall be available to the Dental Director on a sufficiently frequent basis to assist in selection of member's charts for quality assurance audits

c. A description of the specific measures the Plan shall take to improve the accuracy of the Plan's audits and assure its auditors correctly identify significant quality deficiencies in the areas where the Department found the Plan auditor had failed to identify deficiencies. The Plan's response shall set forth a plan for training and monitoring to assure that Plan reviewers are consistently identifying quality of care deficiencies that include, but are not limited to:

Format for medical history forms,
Quantity of radiographs;
Periodontal evaluation and periodontal treatment planning;
Legibility of treatment record notes; and
Treatment sequencing.

d. Revised QA Program policies and procedures that provide for adequate corrective action when the quality of dental services identified by the Plan's dental auditors fails to meet professionally recognized standards. The corrective action plan (CAP) shall include a timeline for actions to be taken and the establishment of appropriate provider sanctions which may be imposed for non-compliance.

It appears there is a lack of appropriate dental records to produce a statistically significant audit. The Plan shall submit a CAP that ensures that an appropriate number of charts (a representative sampling) is available for review at the time of the audit in order to demonstrate Plan's actual utilization of services.

Plan's Compliance Effort 5:

a. The Plan refers to its policy and procedure (Exhibit I, UDC Policy/Procedure, Dental Facility Reviews, revised 9/10/01), Section V, Dental Record Selection, for the process of dental record selection. The Charts that have been pre-selected will be requested at the time of the audit and not prior to the audit.

b. The Plan refers to the above response A. The Plan expects to have this new utilization reporting system in place in the fourth quarter.

c. The Plan is adopting the measures/parameters developed by the California Association of Dental Plan. The Plan will be reviewing the following deficiencies with all QA auditors in their third quarter QA Committee meeting: format for medical history forms; quantity of radiographs; periodontal evaluation and periodontal treatment planning; legibility of treatment record notes; treatment sequencing. The auditors will also renew their certificate by retaking the CADP Procedural Audit course the next time it is offered.

d. The Plan refers to its policy and procedure (Exhibit I, UDC Policy/Procedure, Dental Facility Reviews, revised 9/10/01).

Department's Finding Concerning Plan's Compliance Effort 5:

a. The Plan's revision of the chart selection procedure will take longer than 45 days to implement as it is pending completion of the utilization information referred to in Deficiency 5b.

b. The Plan's proposed correction of this deficiency will take longer than 45 days to implement. The Plan's states it will have a patient utilization information based on two

years of encounter data that will allow patient selection as required in the corrective action and according to Exhibit I (UDC Policy/Procedure: Dental Facility Reviews, Revised 9/10/01). The Plan expects utilization data to be in place in the 4th quarter of 2001.

c, d. The Plan's proposed correction of deficiency 5c and d will take longer than 45 days to implement.

The Department will conduct a Follow-Up Review within 18 months of the date of the Final Report to determine whether the deficiency identified by the Department has been corrected.

Deficiency 6: The Plan did not follow its own standards for Quality Assurance audits.

Section 1370, Rule 1300.70(a)(1), and Rule 1300.70(b)(1)(A) and (B) stated above.

The Department reviewed five provider audit files, each of which had sufficient enrollment that the Plan's audit schedule of at least once every two years should have been followed. The following three examples illustrate the Plan has not followed its own audit standards:

Practice #1 was audited on July 26, 1996. The Plan documented 21 deficiencies and the office was to be re-audited in three months. A letter was sent to the provider documenting the deficiencies, outlining corrective action and notifying the provider of a re-audit in three months. The next audit conducted by the Plan was three and a half years later on January 19, 2000.

Practice #4 was audited on October 7, 1997 and has not been audited since then. A period of 3 ½ years has lapsed since the Plan's last audit of this provider.

Practice #5 was audited on January 30, 1997 and was audited again on March 21, 2001 which is after the Department notified the Plan of offices it had selected to review. The time between audits was over four years.

Corrective Action 6:

The Plan shall submit their schedule of audits for all providers including those with minimal enrollment. The audit schedule should reflect the Plan's QI guidelines or they should submit revised guidelines, as appropriate, reflecting the Plan's current QI audit policies and procedures.

Plan's Compliance Effort 6:

The Plan refers to an attachment (Exhibit G, which lists Facility Name, City and date of the Next Audit) which represents the schedule of audits for providers with minimal to maximum enrollment. The Plan indicates this document reflects its current QI guidelines.

Department's Finding Concerning Plan's Compliance Effort 6:

The proposed schedule of audits and CAP will take longer than 45 days to be completed. The Department will conduct a Follow-Up Review within 18 months of the date of the Final Report to determine whether the deficiency identified by the Department has been corrected.

Deficiency 7: The Plan's Quality Assurance Program did not ensure the consistent identification and correction of quality of care issues at the Plan's orthodontic practices. This is a repeat deficiency.

Section 1370, Rule 1300.70 (a)(1), and Rule 1300.70(b)(1)(A) and (B), stated above.

a. The Plan's orthodontic audit tool was deficient because it did not include a number of important elements.

The Plan's audit instrument contains nine categories or elements of provider services. These are: Informed Consent Form, Medical/Dental History, Intra/Extra Oral Examination, Radiographic Survey, Diagnostic Record, Treatment Plan, Progress Notes, Continuity of Care and Overall Quality of Care. Ratings for each element are either A (Acceptable), U (Unacceptable), N (Not applicable), or C (Cannot evaluate).

The Plan's audit tool was deficient because it did not include the following important items:

- Citing chief complaint
- Evaluation of informed consent
- Final orthodontic records
- The presence or absence of Quality Indicators
- Oral Hygiene monitoring throughout treatment
- Post-treatment care in retention

b. The Plan's method of selecting the sample of patient charts for audits of orthodontic practices was inadequate.

The Plan's orthodontic auditor told the Department that the patient charts are selected by the provider. This allows the dental practice to select only those patient records for which the provider believes an acceptable level of care was provided.

In addition, the Department found instances where the orthodontic auditors selected non-Plan patients for audit. In some offices, the non-Plan patient charts were selected so as to augment the number of treatment charts reviewed, thereby pooling Plan and non-Plan patients. In at least one practice, all ten of the patient charts reviewed were non-Plan patient charts.

c. The Plan's audits of its orthodontic practices did not consistently identify deficiencies in the quality of care.

The following are instances in which the Plan found the quality of care to be acceptable or not applicable whereas the Department found the care below professionally recognized standards of practice:

Practice #6: Deficiencies identified by the Department and not by the Plan

Patient 1 - The provider removed the patient's appliances prematurely because it was suspected that root loss had occurred. At the debanding visit, the patient was given instructions to control a tongue thrust and never recalled. Retainers were not placed.

Patient 2 - The diagnosis and treatment plan failed to identify and plan for treatment of malposed lower second molars.

Practice #7: Deficiencies identified by the Department and not by the Plan

Patient 1 - Chart entries were not signed by the dentist. There was insufficient detail in the diagnosis. Overbite, overjet and arch crowding were not mentioned, and the mesially tipped #31 was neglected in the diagnosis. The treatment plan was deficient because there were no details regarding uprighting the tipped second molar, or resolution of the space created by the loss of the first molar.

Practice #9: Deficiencies identified by the Department and not by the Plan

Patient 1 - Post-treatment x-rays did not include third molar or upper first bicuspid areas. The diagnosis was not acceptable for the following reasons: the anterior open bite was not documented; the improper position of tooth #27 was not documented; the crowding of teeth in the lower was not documented; and the crossbite between teeth #5 and 27 was not documented. The treatment plan failed to document how the anterior open bite or the manner in which the bite relationship on the left side would be corrected. The bite relationship was particularly significant because the case was asymmetrical with a greater occlusal disparity on the left side than the right.

Practice #10: Deficiencies identified by the Department and not by the Plan

Patient 1 - The medical history was not comprehensive because it excluded questions on drugs/medications, certain systems (bones/joints, gastrointestinal, kidney), and left no space for positive responses to any questions. The diagnosis failed to document the poor positioning of the lower second molars. There was no plan of treatment to describe the method to bring the lower second molars into correct position.

Patient 2 - The diagnosis failed to document the following diagnostic features: Class III skeletal tendency; overbite; overjet; and arch length crowding.

Practice #11: Deficiencies identified by the Department and not by the Plan

Patient 1 - The medical history did not include questions on AIDS, HIV for all patients. The diagnosis failed to document the following features: buccal crossbite on the left side; deep overbite; excessive overjet; possible periodontal complications with a protruding lower incisor; and tooth size anomalies of upper lateral incisors. Continuity of care was not assured in one year, the patient missed appointments for three consecutive months with no documented follow-up by the practice.

Patient 3 - The treatment plan failed to indicate how an impacted lower bicuspid would be brought into position.

Practice #12: Deficiencies identified by the Department and not by the Plan

Patient 1 - The diagnosis of the case was deficient for the following reasons: arch length crowding was not documented; midline deviation was not documented; a foreign body, possibly an odontoma, in the position of tooth #16 was not mentioned.

Practice #13: Deficiencies identified by the Department and not by the Plan

Patients 1, 2, and 3 - The medical history was deficient for all the patients from this practice because there were no questions regarding certain systems such as bone and joints, and endocrines and no questions on congenital deformities.

Patient 3 - The continuity of care was not assured in that the patient was not examined for over a six-month period with no reason or follow-up documented in the treatment chart.

d. The Plan did not adequately demonstrate satisfactory provider oversight of their orthodontic practitioners and did not follow their own established policies and procedures. The Plan failed to inform their orthodontic providers of their audit results.

Of 28 providers that were audited since the last Department audit of March 14, 2000, there was no evidence of Corrective Action Plans for nine providers (32%). In addition, for those providers who were sent Corrective Action Plans, seven were not cited for deficiencies found by the Plan at the time of the audit. Omissions included informed consents not witnessed by provider, medical alerts not posted, diagnosis incomplete, treatment plan incomplete, medical history incomplete or not collected, soft tissue findings not cited, TMJ documentation not cited, missing cephalometric radiographs, missing photographs, no follow-up to broken appointments.

In addition, the Plan did not follow up on orthodontic provider responses to Plan audit letters. Although the Plan requests that providers correct deficiencies and reply to the Plan within 15 days, the Dental Director stated that the Plan did not have the ability to verify corrective actions of major deficiencies in a timely manner. The Dental Director stated that the only method the Plan now has in place to assess corrective actions is on the providers next scheduled audit date, however the auditors are not given copies of the last audit when they conduct an audit.

Corrective Action 7:

The Plan shall submit a Corrective Action Plan that eliminates the co-mingling of Plan and non-Plan enrollee charts in Plan's audit process. The Plan shall submit a revised audit tool which demonstrates appropriate measures representative of dental Quality Issues and the timetable when compliance will be achieved as well as details regarding the implementation of appropriate follow-up measures and sanctions taken against providers that do not meet audit standards. The CAP shall include timeframes for all activities.

Plan's Compliance Effort 7:

To eliminate the co-mingling of Plan and non-Plan chart audits, the Plan will implement a pre-authorization of all orthodontic referrals. The Plan refers to two attachments (Exhibit J: undated UDC letterhead indicating pre-authorization for all orthodontic referrals for UDC patients is in effect; and Exhibit K: UDC Specialty Care Referral Form) that represent the cover letter of notification to the providers and a sample revised referral form regarding orthodontic referrals. This will identify Plan patients in treatment at Plan orthodontic offices. At the time the audit is to be performed, the names of the Plan patients in treatment will be given to the orthodontic auditor as the only charts to be audited. This pre-authorization form is being developed and will be ready for use in the fourth quarter of 2001. At that time it will be sent to all general dentist providers on the Plan with a notice of how to submit for pre-authorization of orthodontic referrals. The Plan expects to begin QA audits of orthodontic practices in the first quarter of 2002. The Plan refers to an attachment (Exhibit H: UDC Orthodontic Criteria & Guidelines and Provider Facility Review, 9/13/01) for the revised audit tool, criteria, and guidelines which demonstrate appropriate measures representative of dental quality issues.

Department's Finding Concerning Plan's Compliance Effort 7:

The proposed CAP and changes to UDCs Policies and Procedures will take longer than 45 days to implement. The Department will conduct a Follow-Up Review within 18 months of the date of the Final Report to determine whether the deficiency identified by the Department has been corrected.

Deficiency 8: The Plan's Quality Assurance Program failed to demonstrate adequate evidence of credentialing and recredentialing of providers. This is a repeat deficiency.

Section 1367(b) states, in part that all personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

Section 1370 and Rule 1300.70(b)(1)(A) and (B), stated above.

a. The Plan does not credential or monitor the credentialing all of the dentists in its practices who provide care to Plan enrollees. The Plan's Quality Assurance

Program did not demonstrate adequate evidence of credentialing and recredentialing of providers because the Plan did not credential or recredential all the dentists in the practices who provide services to Plan enrollees. If the Plan delegated this function to the owners of its practices, the Plan did not follow-up to ensure that the owner dentist had in fact credentialed the dentists in his or her office.

b. The Plan did not have current credentialing information for three providers. The Plan's Quality Assurance Program did not demonstrate adequate evidence of credentialing and recredentialing of providers because the Department's review of five randomly selected provider files showed that the license for three of those providers had expired. The Dental Board license for Provider #14 expired March 31, 2001, the Dental Board license for Provider #15 expired March 31, 2001, and the Dental Board license for Provider #16 expired November 30, 2000.

Corrective Action 8:

The Plan must clarify if its contracted providers are delegated the responsibility for verifying licensure. If the Plan's providers are not delegated the responsibility for verifying licensure, the Plan must have a mechanism to verify that the contractor is aware of the current licensure of his/her employees and subcontractors. The Department encourages the Plan to be knowledgeable of all practitioners who provide services to their enrollees. In order to accomplish this goal, the Plan shall implement a credentialing/recredentialing policy and procedure in order to ensure enrollee's are receiving appropriate professional dental and orthodontic services by licensed practitioners.

Plan's Compliance Effort 8:

The Plan encourages the providers to submit any changes in their staff. However, the responsibility is not actually delegated to them. At the time for recredentialing a provider, notice is sent to the office for an update on this provider and any changes in other provider activity in the office. Also, the Plan will begin working with the Dental Director in obtaining any new provider information via the QA audits of general dentist and orthodontic offices. The auditors check the records of all of the providers currently practicing in the office, along with their dental license numbers. This information will be given to the QI specialist after each audit for comparison to the Plan's records. Provider files will be updated accordingly. Providers no longer in the office will be removed from active status. New providers will be immediately credentialed, and current providers will be recredentialed if necessary.

Department's Finding Concerning Plan's Compliance Effort 8:

The Plan's proposed corrective action does not indicate any positive change in the credentialing system from the time of the Department's on-site review. The apparent change noted is the absence of the QI Specialist, who was responsible for all credentialing and re-credentialing

activities. The Vice President of Operations is currently responsible for credentialing and re-credentialing activities.

The Plan's CAP is not adequate to remedy the deficiency as requested. The Department will conduct a Follow-Up Review within 18 months of the date of the Final Report to determine whether the deficiency identified by the Department has been corrected.

C. Grievance System

Deficiency 9: The Plan did not ensure adequate or timely follow up of grievances to determine whether grievances are representative of systemic problems with providers and to initiate appropriate corrective actions, where necessary.

Rule 1300.68 states, in part, that every health care service plan shall establish a grievance system pursuant to the requirement of Section 1368 of the Act. Rule 1300.68(a) states, in part, that the grievance system shall be established, pursuant to written procedures, for the receipt, handling and resolution of complaints within 30 calendar days of receipt by the plan, or the entity contracted by the plan to administer its grievance system.

Rule 1300.70(a)(1) states, in part, that the Quality Assurance (QA) program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Rule 1300.67.2(f) states, in part, that each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

The Department found inadequate evidence to demonstrate that the Plan followed up enrollee complaints that dealt with difficulties in accessing care, including follow up with provider offices, to assure that access problems were adequately investigated and corrected. The following complaints are illustrative of this deficiency. For each of these cases, the Department found no evidence that the Plan conducted adequate follow-up to address the access-related issues that were raised.

Case 1: The member complained of a dirty office, unsanitary conditions and unreasonable waiting time in the office. The Plan made a phone call to the office, but no Plan staff visited the office to observe the office cleanliness. The allegation of unreasonable waiting time in the office was not addressed.

Case 2: There was no follow up with the provider to determine if the member's allegation of refusal to treat was true. The grievance was closed in favor of the provider because the member failed to return a written UIR.

Case 4: The Plan followed up with the provider and confirmed the member's complaint of a six-

week wait for an initial examination appointment. Six weeks is outside the Plan's accessibility standards of three weeks for an initial appointment, yet there was no action by the Plan.

As discussed in Plan Organization, Deficiency 1, the survey team found an inadequate level of professional staffing responsible for the management and operation of the Plan's grievance program.

- The Grievance/Resolution Coordinator is no longer employed by the Plan and that position is vacant. From information gained during interviews of Plan staff, the Grievance/Resolution Coordinator position will not be filled.

- The Plan no longer employs provider service representatives in the field. These representatives formerly conducted new provider recruitment, facility audits, access monitoring and follow up on grievance issues that may have involved a systemic issue.

- The Vice President Operations is presently responsible for grievance resolution, customer service, provider relations, and almost all administrative functions except those directly related to the Dental Director. It is unclear who will conduct those functions that were formerly the responsibility of the QI Specialist and Grievance/Resolution Coordinator.

Corrective Action 9:

The Plan shall ensure adequate professional staff is located within reasonable proximity to manage and direct the grievance program. The CAP shall identify and include, but not limited to, that the Quality Assurance Program monitors patterns of grievances to identify systemic problems, the details regarding how the Plan intends to comply with the timely and appropriate follow-up and handling of enrollee complaints and grievances, any changes or development of policies and procedures or organizational systems necessary and the individual(s) responsible for implementing the corrective action, and the timeframe by which the deficiency will be corrected.

Plan's Compliance Effort 9:

The Plan refers to its response to Deficiency 2 regarding the staff responsible for grievance resolution. The grievance report (prepared quarterly) is given to the Q. A. Committee at their quarterly meeting. If any patterns of grievances appear that identify systemic problems, the committee will decide on the appropriate action and notify the provider. The Plan has complied, and will continue to comply, with the 30-day time frame to resolve grievances in all cases this year except for one, In this case the provider had terminated his participation, and it took several requests to get a response from him.

Department's Finding Concerning Plan's Compliance Effort 9:

The Plan's response, in part, to Deficiency 9 was for the Department to refer to their response to Deficiency 2 regarding the staff responsible for grievance resolution. Deficiency 2 pertains to

Plan's inability to ensure that only educationally qualified orthodontists will provide orthodontic care to enrollee's and was not related to this Deficiency.

The Plan's CAP is not adequate to remedy the deficiency as requested. The Department will conduct a Follow-Up Review within 18 months of the date of the Final Report to determine whether the deficiency identified by the Department has been corrected.

D. Continuity of Care

Deficiency 10: The Plan has adopted limitations on referrals for children for pedodontic services based on age.

Section 1367(d) states, in part, that a plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

Section 1367(e)(1) states, in part, that all services be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.

Section 1363.5(a) states, in part, that the plan use's criteria for approving services which are developed with involvement from actively practicing providers, using sound clinical principles and processes, and evaluated and updated if necessary, at least annually.

The Plan limits care based upon enrollee's age. The Plan fails to consider the health care needs of the individual and/or any extenuating circumstances surrounding the provision of care to the enrollee. The Department's review found that the Plan's referral guidelines limit pedodontic referral for children age 5 and older who present a management problem for a general dentist. Children age 5 and older who are management problems are not eligible for referral to a pedodontist. This exclusion is solely based on age and does not take into consideration the ability of the patient to receive dental treatment or the provider to deliver necessary services. This exclusion creates a number of potential problems for enrollees. Dentists' skills in managing patients differ so an enrollee would not know if treatment was excluded because management of the case was beyond the scope of practice for most dentists or because it was simply beyond the skill of the particular treating dentist. Management of children is an area where the difference in skills of dentists is often seen.

The Department's review of the Plan's guideline for pediatric specialty referral found that it does not ensure that pediatric members will be referred for specialty services according to professional standards of care. Current professionally recognized standards of care require referral of young children with medical or behavioral management problems to a pediatric dentist if the general dentist is unable to treat the patient. The Department found that the Plan's referral guideline relies solely on age, and does not allow for behavioral or medical problems.

Corrective Action 10:

The Plan shall submit a CAP, to revise its specialty referral guidelines, and dissemination of revised guidelines to all contracting dental providers, to eliminate restrictions that are strictly age based which impede continuity of care for pedodontic care. The Plan shall demonstrate that specialty referral guidelines are regularly reviewed by participating network practitioners.

Plan's Compliance Effort 10:

The pedodontic referral guidelines are found in Chapter 7, page 10, of the Dentist Office Reference Manual, and state, in part: *"Treatment for children under the age of five may be referred to the pediatric dentist after having been assessed by the Family Dentist. Treatment for children between their fifth and sixth birthdays may be referred only if there is widespread decay, including involvement of the pulp, in more than four teeth. The Family Dentist should make a worthy effort to treat children in their practice. In the event the Family Dentist is unable to gain the cooperation and compliance of the child, it becomes the parent's responsibility to ensure the child's compliance. If this cannot be achieved, the parents must assume the financial responsibility for their child's care at the specialist's office. Referral for lack of patient compliance (behavioral management) is not a covered benefit. Complicating factors of a case that require the referral of a child over the age of five may include, but are not limited to, special medical problems, severe systemic disease, genetic conditions and developmental problems. Such conditions should be noted on the referral form."*

The Plan's coverage included routine general dentistry procedures that are a covered benefit when performed by the member's chosen general dentist. Members are not covered to see a specialist for these routine procedures that a general dentist is capable of and willing to perform. This holds true for pedodontic care. If the general dentist is capable of treating children but the only reason preventing him from doing do is the member (i.e., the unmanageable child), then specialty care is not a covered benefit. Managed care plan coverage provides for routine dental services at the general dentist and the specialist when procedures are beyond the scope of the general dentist. Procedures needing to be performed on unmanageable children are not beyond the scope of the general dentist. Therefore, the coverage is provided by the general dentist, and not a specialist. The Plan believes its referral policies for children over the age of five are within the definitions of plan coverage. These are policies that have been previously approved by the Department.

Department's Finding Concerning Plan's Compliance Effort 10:

The Plan restates that its referral policies for children over the age of five are within the definitions of plan coverage. The Plan referenced their pedodontic referral guidelines that are found in the UDC Dentist Office Reference Manual.

The Plan has corrected this deficiency as requested.